STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445487	A. BUILDING _____ B. WING _____	04/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF JOHNSON CITY, INC	140 TECHNOLOGY LANE JOHNSON CITY, TN 37604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure privacy during a treatment for one (#2) of eighteen residents reviewed. The findings included:	F 164	Disclaimer for Plan of Correction Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Johnson City of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Johnson City files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings. **F 164** Christian Care Center of Johnson City believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/11/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 Resident #2 was admitted to the facility on February 18, 2011, with diagnoses including Intracranial and Intraspinal Abscess, Osteomylelitis, and Hypertension. Observation on April 25, 2011, at 5:10 p.m. revealed resident #2 lying on the bed next to the window. Further observation revealed LPN (Licensed Practical Nurse) #3 exposed the resident's abdomen and administered Humulin R insulin 6 units without closing the blinds. Interview on April 25, 2011, at 5:20 p.m., in the hall, with LPN #3, confirmed the blinds were not closed during the administration of the insulin.	F 164	Corrective Actions for Targeted Residents On 4/27/11, LPN #3 was counseled regarding resident privacy and importance of closing window blinds when administering insulin. Licensed Nursing staff was in-serviced by the Director of Nursing on 5/5/11 regarding providing privacy for resident #2 and any other residents receiving injections/treatments of any form. Identification of Other Residents with Potential to be Affected Due to the nature of this practice, current residents have the potential to be affected.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272	Systematic Changes Licensed Nurses were educated by the Director of Nursing on 5/5/11 regarding the need to provide privacy, including closing of blinds, when administering insulin injections or treatments. Education of new Licensed Nurses will also include the need for full privacy when administering any type of injection or treatment. Monitoring The Director of Nursing will monitor 10% of Licensed Nurses for 3 months while they are administering injections/treatments to ensure that privacy is being maintained during the procedure. The Director of Nursing will report these findings to the Performance Improvement Committee for review and determination of on-going compliance. This committee consists of	

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F 164	Continued From page 1 Resident #2 was admitted to the facility on February 18, 2011, with diagnoses including Intracranial and Intraspinal Abscess, Osteomylelitis, and Hypertension. Observation on April 25, 2011, at 5:10 p.m. revealed resident #2 lying on the bed next to the window. Further observation revealed LPN (Licensed Practical Nurse) #3 exposed the resident's abdomen and administered Humulin R insulin 6 units without closing the blinds. Interview on April 25, 2011, at 5:20 p.m., in the hall, with LPN #3, confirmed the blinds were not closed during the administration of the insulin.	F 164	the Administrator, Consultant Pharmacist, Medical Director, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Housekeeping/ Laundry Supervisor, MDS/Care Plan Coordinator, Director of Social Service, Clinical Records Supervisor, Dietary Manager, and Activities Director.	6/1/11
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272	**F 272** Christian Care Center of Johnson City believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Action for Targeted Residents</u> An assessment of Resident #11's wandering behaviors was completed and a care plan was completed for this resident on 5/5/11, which includes interventions for this resident's wandering behaviors. <u>Identification of Other Residents with Potential to be Affected</u> Charts of residents who have wandering type behaviors were audited by the Social	

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F 272	Continued From page 2 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to complete a behavior assessment for care planning for one resident (#11) of eighteen residents reviewed. The findings included: Resident #11 was admitted to the facility with diagnoses including, Senile Dementia, Hypertension, Atrial Fibrillation, Hypothyroidism, and Muscle Weakness. Medical record review of the Minimum Data Set (MDS) dated March 22, 2011, revealed the resident was cognitively impaired and had behaviors of wandering, entering other resident's rooms, rummaging through others' belongings, and taking things. Interview with four residents during a group meeting on April 26, 2011, at 10:00 a.m., in the	F 272	Service Director on 5/10/11 to ensure that they have an assessment of behaviors and that a care plan has been developed with interventions for the residents' wandering behaviors. Systematic Changes The Social Service Director was educated by the MDS Coordinator on 5/9/11. The education included the need to ensure that residents with wandering type behaviors have an assessment of behaviors and that a care plan has been developed with interventions for the residents' wandering behaviors. Monitoring Charts of current residents with wandering type behaviors will be reviewed by the MDS Coordinator. This review will be completed on 5/12/11. New admission residents with wandering type behaviors will have an assessment and a care plan to address wandering behaviors no later than 14 days after admission to the facility. The MDS Coordinator will audit new admission charts to ensure that there has been an assessment on wandering type behaviors and that appropriate interventions are care planned. Chart reviews for new admission residents with wandering type behaviors will continue for three months. The MDS Coordinator will report these findings to the Performance Improvement Committee for review and determination of ongoing compliance. This committee consists of the Administrator, Consultant	

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F 272	Continued From page 3 Activities Room, revealed wandering residents entering their rooms and taking belongings was an ongoing concern for them. Interview with the Administrator on April 27, 2011, at 9:00 a.m. confirmed staff were aware there were cognitively impaired residents wandering and going into other resident's rooms. Interview with the Activities Director on April 27, 2011, at 1045 a.m. confirmed Resident #11 had been observed on several occasions going into other resident's rooms. Continued interview confirmed staff were aware and could usually redirect the resident to another activity. Interview with the Director of Nursing (DON), in the DON's office, April 27, 2011, at 2:15 p.m., confirmed the facility had failed to provide an assessment for care planning and develop interventions for the resident's wandering behaviors.	F 272	Pharmacist, Medical Director, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Housekeeping/ Laundry Supervisor, MDS/Care Plan Coordinator, Social Service Director, Clinical Records Supervisor, Dietary Manager, and Activities Director.	6/1/11
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to label a tube feeding set and the tube feeding container for one resident (#1) of eighteen residents reviewed. The findings included: Resident #1 was admitted to the facility on March	F 281	**F 281** Christian Care Center of Johnson City believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Residents</u> On 4/27/11, the tube feeding set and tube feeding container for Resident #1 were changed out and the new tube feeding set and tube feeding container were labeled with the resident's name,	

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F 281	Continued From page 4 10, 2009, with diagnoses including Parkinson's Disease, Dysphagia, Atrial Fibrillation, and Gastrostomy Tube. Medical record review of a physician's order dated April 1, 2011, revealed "...Fibersource HN via PEG (percutaneous endoscopic gastrostomy) @ 70cc/hr (cubic centimeters per hour)..." Observation on April 25, 2011, at 11:15 a.m., revealed Resident #1 in bed, a tube feeding pump at bedside infusing Fibersource HN in a container, unlabelled with the resident's name, at 70 cc per hour into the PEG tube through an unlabeled, undated tube feeding set. Interview with LPN #1 on April 25, 2011, at 11:20 a.m., confirmed the tube feeding was unlabelled with the resident's name, date, time started, and infusion rate as per standard of practice.	F 281	date, time started, and infusion rate as per the standard of practice. Identification of Other Residents with Potential to be Affected Current residents receiving tube feeding have the potential to be affected. On 4/27/11, the ADON audited tube feeding sets and tube feeding containers that were in place for other residents in the facility receiving enteral feedings to ensure that tube feeding sets were dated and feeding containers were labeled with residents' name, date, time started and infusion rate per the standard of practice. Systematic Changes Licensed Nurses were educated by the Director of Nursing on 5/5/11 regarding the need for labeling tube feeding sets and tube feeding containers with the resident's name, date, time started, and the infusion rate per the standard of practice. Monitoring The Assistant Director of Nursing will audit on a weekly basis for three months the tube feeding sets and tube feeding containers of any new or current residents receiving enteral feedings to ensure that the tube feeding sets and tube feeding containers are labeled with the resident's name, date, time started and infusion rate. The Director of Nursing will report these findings to the Performance Committee for review and determination of on-going compliance. This committee consists of the	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, policy review, and interview, the facility failed to	F 315		

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F 281	Continued From page 4 10, 2009, with diagnoses including Parkinson's Disease, Dysphagia, Atrial Fibrillation, and Gastrostomy Tube. Medical record review of a physician's order dated April 1, 2011, revealed "...Fibersource HN via PEG (percutaneous endoscopic gastrostomy) @ 70cc/hr (cubic centimeters per hour)..." Observation on April 25, 2011, at 11:15 a.m., revealed Resident #1 in bed, a tube feeding pump at bedside infusing Fibersource HN in a container, unlabelled with the resident's name, at 70 cc per hour into the PEG tube through an unlabeled, undated tube feeding set. Interview with LPN #1 on April 25, 2011, at 11:20 a.m., confirmed the tube feeding was unlabelled with the resident's name, date, time started, and infusion rate as per standard of practice.	F 281	Administrator, Consultant Pharmacist, Medical Director, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Housekeeping/ Laundry Supervisor, MDS/Care Plan Coordinator, Social Service Director, Clinical Records Supervisor, Dietary Manager, and Activities Director.	6/1/11
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, policy review, and interview, the facility failed to	F 315	**F 315** Christian Care Center of Johnson City believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Residents</u> Resident #9 is currently receiving appropriate incontinent care to prevent UTIs according to policy and procedures. On 4/27/11, CNA's #1 and #2 were educated by the Director of Nursing regarding providing appropriate incontinent care.	

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F 315	Continued From page 5 provide appropriate incontinent care for one resident (#9) of eighteen residents reviewed. The findings included: Resident #9 was readmitted to the facility on December 8, 2009, with diagnoses including Atrial Fibrillation, Hemiplegia and Hemiparesis Left side. Medical record review of the Minimum Data Set dated March 28, 2011, revealed the resident was frequently incontinent of bladder and required total assist for toileting. Observation on April 27, 2011, at 8:50 a.m., in the resident's room, revealed CNA #1 and CNA #2 (certified nursing assistant) providing incontinence care to the resident. Continued observation revealed both CNA's donned gloves and assisted the resident from wheelchair to the bed. Continued observation revealed CNA #2 removed the pants, and untaped the brief, CNA #2 sprayed peri wash on the perineal area, CNA #1 cleaned the perineal area in a circular motion, rolled the resident to the left side, cleaned the buttocks area without changing wipes or folding the wipe. Further observation revealed CNA #2 placed brief on the resident, and without changing gloves or disinfecting the hands placed the linen (sheet and blanket) on the resident, adjusted the remote for the bed position, and continued to place the resident's stuffed animals in the bed. Review of the facility's policy Perineal Care revealed "...8...wash ...using gentle down strokes from front to back of the perineum...10 ..starting...wiping from front to back...17. Remove gloves and discard. 18. Wash hands."	F 315	Identification of Other Residents with Potential to be Affected Due to the nature of this practice, current residents requiring incontinent care have the potential to be affected. Systematic Changes CNA staff was educated by the Director of Nursing on 5/5/11 regarding the need to provide incontinent care according to the facility's policy. Upon hire, CNAs will be in-serviced on proper incontinent care with a return demo by way of competency testing. Monitoring The Director of Nursing will monitor the CNA staff performing incontinent care to ensure that the facility policy is being followed. A 10% sample of CNAs will be monitored during incontinent care each month for three months. The Director of Nursing will report these findings to the Performance Improvement Committee for review and determination of on-going compliance. This committee consists of the Administrator, Consultant Pharmacist, Medical Director, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Housekeeping/ Laundry Supervisor, MDS/Care Plan Coordinator, Social Service Director, Clinical Records Supervisor, Dietary Manager, and Activities Director.	6/1/11

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F 315	Continued From page 6 Interview with CNA #1 and CNA #2 on April 27, 2011, at 8:55 a.m., in the hallway, confirmed the CNA's had failed to follow the facility's policy for providing appropriate incontinence care and had failed to remove gloves or disinfect hands after providing care.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility investigations, observation, and interview, the facility failed to ensure safety devices were in place and functioning to prevent falls for one (#8) resident and failed to implement interventions to prevent dislodgement of a intravenous line for one (#2) resident of eighteen residents reviewed. The findings included: Resident #8 was admitted to the facility on February 11, 2011, with diagnoses including Alzheimer's Disease, Atrial Fibrillation, Diabetes, and Hypertension. Medical record review of fall risk assessments	F 323	**F 323** Christian Care Center of Johnson City believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Residents</u> Resident #8 was re-assessed on 5/10/11 for proper safety device needed to prevent falls. It was determined that appropriate safety device was in place. Resident #2 has expired due to unrelated causes. <u>Identification of Other Residents with Potential to be Affected</u> Current residents requiring safety devices and intravenous lines have the potential to be affected.	

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F 323	Continued From page 7 dated December 31, 2010, and April 19, 2011, revealed the resident was at high risk for falls. Medical record review of the care plan reviewed on March 4, 2011, revealed, "...7/13/09 Low bed with mats to floor, shortened cord on clip alarm to bed...9-29-10 Add short cord clip alarm in addition to pad alarm while (up) in geri-chair..." Medical record review of the Interdisciplinary Progress Note dated November 9, 2010, revealed,"...(resident) discovered in floor in front of (reclined) G (geri)-chair...Clip alarm sounding faintly...no red or bruised areas noted..." Review of the post fall evaluation dated November 9, 2010, revealed, "...Resident fell: from chair...what care planned interventions were in place prior to the fall? Clip alarm (and) (reclined) G-chair..." Review of the post fall evaluation dated March 19, 2011, 6:20 p.m., revealed, "...Resident fell: from bed...Resident was observed on the floor...(no) injuries noted...Interventions in place and functioning at time of the fall? (blank)..." Medical record review of the Interdisciplinary Progress Note dated March 19, 2011, revealed, "6:20 p (p.m.) Resident observed on floor on hands (and) knees trying to get up...Resident observed several times trying to get out of bed..." Review of the post fall evaluation dated April 19, 2011, revealed, "...Resident fell: from bed...Observed in floor after daughter had put resident to bed...was laying on the floor by bed...No alarms, low bed or mat were in use. No injuries observed or pain...What new	F 323	Systematic Changes On 5/11/11, the Interdisciplinary Team met with Resident #8's daughter. The need for the safety device for the resident was addressed. As a measure of caution, the resident's daughter was reminded by the Director of Nursing to ask staff to assist with transfer of resident. Nursing staff was educated by the DON on 5/5/11 regarding the need to ensure that safety devices are in place and functioning to prevent falls. The facility will be utilizing arm/hand boards and gauze as the intervention to prevent dislodgement of intravenous lines. The facility will continue to assess residents with safety devices every two hours, or more if needed, to ensure safety devices are in place. Monitoring Residents requiring safety devices and intravenous lines will be audited by the Assistant Director of Nursing. The safety device audit will consist of the type of safety device, and ensure that the device is in place and functioning properly. The audit for intravenous lines will include patency and that proper assistance device is in place to prevent dislodgement of the intravenous line. These audits will be reviewed by the Director of Nursing and reported by the Director of Nursing to the Performance Improvement Committee monthly for three months to ensure compliance. This committee consists of the Administrator, Consultant Pharmacist,	

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F 323	Continued From page 8 interventions are in place to prevent further falls? Daughter called...counseled (and) notified of fall..." Interview on April 26, 2011, at 12:35 p.m., in the conference room, with the Director of Nursing, and the Assistant Director of Nursing, confirmed undetermined if the alarm was in place and functioning at the time of the fall on November 9, 2010, and March 19, 2011. Further interview confirmed the safety devices were not in place at the time of the fall on April 19, 2011. Resident #2 was admitted to the facility on February 18, 2011, with diagnoses including Intracranial and Intraspinal Abscess, Osteomylelitis, and Hypertension. Medical record review of the Interdisciplinary Progress Note dated February 26, 2011, revealed, "...New order to restart an INT (intravenous needle). INT restarted in residents (left) wrist...Secured (with) tape and gauze..." Medical record review of the Interdisciplinary Progress Note dated February 27, 2011, revealed, "...Entered residents room...Observed INT that was inserted earlier this shift on floor...obtained order to restarting an IV in (left) forearm for antiblotic use..." Medical record review of the Interdisciplinary Progress Note dated March 18, 2011, revealed, "...Res. (resident) observed lying in bed. All clothing on floor INT on floor as well..." Medical record review of the Interdisciplinary Progress Note dated March 21, 2011, 2:15 p.m.,	F 323	Medical Director, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Housekeeping/ Laundry Supervisor, MDS/Care Plan Coordinator, Director of Social Service, Clinical Records Supervisor, Dietary Manager, and Activities Director.	6/1/11

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F 323	Continued From page 9 revealed, "...INT placed into (left) wrist...11:50 p (p.m.) Observed resident INT on side of bed...had pulled it out..." Interview on April 26, 2011, at 2:40 p.m., with the Assistant Director of Nursing, in the conference room, confirmed no new interventions had been implemented to ensure the resident's INT was secure.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the Rules and Regulations of Licensed Practical Nurses, observation, and interview, the facility failed to ensure demonstrated competency prior to performing a procedure for one (#2) of eighteen residents reviewed. The findings included: Resident #2 was admitted to the facility on February 18, 2011, with diagnoses including Intracranial and Intraspinal Abscess,	F 328	**F 328** Christian Care Center of Johnson City believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Action for Targeted Residents</u> Resident #2 has expired due to unrelated causes. <u>Identification of other Residents with Potential to be Affected</u> Current residents with PICC lines have potential to be affected by this practice. <u>Systematic Changes</u> LPNs were educated on 5/5/11 by the Director of Nursing regarding performing only those tasks for which each has been prepared and has demonstrated ability to perform. Direct care for PICC lines will be performed by a Registered Nurse. The RN will supervise delegated duties of the LPNs regarding PICC lines.	

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F 328	Continued From page 10 Osteomyelitis, and Hypertension. Medical record review of the physician's recapitulation orders dated April 15, 2011, through April 30, 2011, revealed, "...Cefepime (antibiotic) 2gm (grams) in 50 ml (milliliter) NS (normal saline)...intravenous...every 8 hours..." Observation on April 26, 2011, with LPN (Licensed Practical Nurse) #1 performing the PICC (peripherally inserted central catheter) line flush revealed the following: LPN #1 entered the resident's room, washed the hands and donned gloves, cleaned the port of the PICC line with alcohol, flushed the port with 20 milliliters normal saline, changed gloves, cleaned the port of the PICC line with alcohol, and attached the tubing with the IV (intravenous) antibiotic to the PICC line. Review of the Rules and Regulations of Licensed Practical Nurses, Rule 1000-2-.04 (3) (a) and (c), dated June 2007, revealed, " ...(a) ...Licensed Practical Nurses are liable if they perform delegated functions they are not prepared to handle by education and experience and for which supervision is not provided. In any patient care situation, the licensed practical nurse should perform only those tasks for which each has been prepared and has demonstrated ability to perform ...(c) Before performing activities requiring greater skill and knowledge, the following criteria must be met ...The individual must demonstrate competency in the practice..." Interview on April 26, 2011, at 1:45 p.m., with the Director of Nursing, in the conference room, confirmed no documentation of demonstrated competency had been completed for LPN #1 prior	F 328	Monitoring The Director of Nursing will monitor PICC lines in the facility for 3 months, then quarterly, to ensure that RNs are performing direct care for these lines, and supervising delegated duties of the LPNs regarding these lines. These findings will be reported to the Performance Committee for review and determination of on-going compliance. This committee consists of the Administrator, Consultant Pharmacist, Medical Director, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Housekeeping/ Laundry Supervisor, MDS/Care Plan Coordinator, Director of Social Service, Clinical Records Supervisor, Dietary Manager, and Activities Director.	6/1/11

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F 328	Continued From page 11 to performing the PICC line flush or administering the antibiotic.	F 328		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on policy review, review of the menus, observation, and interview, the facility failed to ensure stacked pans were clean, failed to ensure sanitizing liquid was separated from food, and failed to ensure the correct scoop sizes were used for one meal. The findings included: Observation on April 25, 2011, at 10:35 a.m., with the CDM (Certified Dietary Manager) revealed one stacked quarter pan on the drying rack with a small amount of debris on the side of the pan, and a 5 liter bucket with 3 liters of saniquat (sanitizing solution) sitting under the serving line next to six covered bowls of corn flakes. Review of the facility policy, Pots and Pans, revealed, "...It is the policy of this facility to clean and sanitize pots and pans to maintain sanitary food preparation, service and delivery	F 371	**F 371** Christian Care Center of Johnson City believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Action for Targeted Residents</u> The quarter pan was washed and sanitized on 4/26/11 by the Dietary Manager, according to facility policy. On 4/26/11, the Dietary Manager removed the sanitizing solution that was near the food. The 3 oz. scoop that was used to serve the beets was changed by the Dietary Manager to a 4 oz. spoodle on 4/26/11. The 2 oz. scoop being used to serve the super mashed potatoes was replaced with a 4 oz. scoop by the Dietary Manager on 4/26/11. <u>Identification of Other Residents with Potential to be Affected</u> Due to the nature of this practice, current residents have the potential to be affected.	

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F 371	Continued From page 12 environment..." Interview on April 26, 2011, at 10:36 a.m., with the Dietary Manager, in the kitchen, confirmed the quarter pan needed to be washed, and the sanitizing solution was not to be sitting next to food. Observation on April 26, 2011, at 5:00 p.m., of the tray line revealed a 3 ounce scoop was used to serve the beets, and a 2 ounce scoop was used to serve the super mashed potatoes. Review of the facility's menus revealed, "...Beets 4 z (ounce) spoodle..." Interview on April 26, 2011, at 5:00 p.m., with the Registered Dietician, in the kitchen, confirmed a 4 ounce scoop (spoodle) was to be used for the beets, and a 4 ounce scoop was to be used for the super mashed potatoes. Interview on April 26, 2011, at 5:00 p.m., with the Dietary Manager, in the kitchen, confirmed approximately fourteen trays had been served.	F 371	Systematic Changes Dietary Staff was educated by the Dietary Manager on 4/28/11 regarding the need to ensure that pans are washed according to facility policy, that sanitizing solution is not left near food items, and that foods should be served with the appropriate size and appropriate type of scoop according to the menu. Monitoring The Dietary Manager, with the assistance of the Registered Dietician, will monitor to ensure that pans are cleaned according to facility policy, that sanitizing solution is not left near food, and that foods are served with the appropriate size and appropriate type of scoop according to the menu. These items will be audited on a weekly basis for three months. The Dietary Manager will report these findings to the Performance Improvement Committee for review and determination of on-going compliance. This committee consists of the Administrator, Consultant Pharmacist, Medical Director, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Housekeeping/ Laundry Supervisor, MDS/Care Plan Coordinator, Director of Social Service, Clinical Records Supervisor, Dietary Manager, and Activities Director.	6/1/11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 13 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to ensure infection control strategies were maintained for two residents (#14, #2) for medication pass; for one resident (#3) for dressing change; and ensure the water fountain was clean. The findings included: Resident #14 was admitted to the facility on September 24, 2009, with diagnoses including	F 441	**F 441** Christian Care Center of Johnson City believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Action for Targeted Residents</u> On 4/28/11, LPNs #2 and #4 were in-serviced by the Director of Nursing on the need to disinfect and/or wash hands prior to and after medication administration and during and after performing a clean dressing change. On 4/27/11, the restroom key was removed from the water fountain by the ADON, and the fountain was immediately disinfected. On 5/10/11, the male resident who placed the restroom key in the fountain was educated by the Administrator to place the key back on the wall hanger when finished. <u>Identification of Other Residents with Potential to be Affected</u> Current residents receiving medication or requiring dressing changes have the potential to be affected. Any person utilizing the water fountain has the potential to be affected.	

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F 441	Continued From page 14 Hypertension, Muscle Weakness, and Late effects of Cerebral Vascular Accident. Observation during walk through on April 25, 2011, at 11:00 a.m., in the hallway, revealed LPN #2 (licensed practical nurse) preparing to administer medication to resident #14. Continued observation revealed LPN #2 retrieved medication from the medication cart, went to the resident's room, and gave medication to the resident. Continued observation revealed LPN #2 did not use hand disinfectant or wash hands prior to administering medication or after administering the medication to the resident. Interview with LPN #2 on April 25, 2011, at 11:05 a.m., in the hallway, confirmed had not disinfected hands prior to or after administering the medication to the resident. Resident #3 was admitted to the facility on August 18, 2009, with diagnoses including Congestive Heart Failure, Atrial Fibrillation, Muscle Weakness, and Hyperthyroidism. Observation on April 26, 2011, at 9:00 a.m., revealed LPN #4 preparing supplies outside the resident #3's room for a dressing change. Continued observation revealed the following breaches in infection control practices: 1) the LPN donned gloves and placed a barrier on the treatment cart, disinfected the scissors and placed on barrier, using the same gloves, opened the treatment cart's drawers and retrieved supplies for the dressing change, 2) after the dressing change was completed LPN #4 placed a sock on the resident's toes, with the same gloves, went to the bedside cabinet and placed the tape in the drawer, returned to the bed, gathered	F 441	Systematic Changes Licensed Nursing staff was educated by the Director of Nursing on 5/5/11 regarding the proper procedure for sanitizing or washing hands according to facility policies. Licensed Nursing staff will be in-serviced upon hire and annually by the DON on proper hand-washing per facility policy. On 5/10/11, the restroom key hanger was lowered by the Maintenance Director to provide easier access for residents in wheelchairs to remove and replace the restroom key. Monitoring Medication administration and clean dressing changes will be audited by the Assistant Director of Nursing daily (Monday thru Friday) for four weeks, and then monthly for three months. The audit will include daily observation of three medication administration passes on each shift and two dressing changes (Monday thru Friday) to ensure proper hand washing. The Consultant Pharmacist will assist in medication administration audits on monthly visits for three months. The Housekeeping Supervisor will audit the drinking fountain in the main lobby daily for one month to ensure that items are not placed in the drinking fountain. The audit will be reviewed by the Administrator and reported to the Performance Improvement Committee.	

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F 441	Continued From page 15 unused supplies and placed in red bag, tied the bag, opened the resident's door, placed red bag in trash container on the side of the treatment cart. Review of the facility policy Dressing Change revealed ...16. Remove and discard gloves. Interview with LPN #4 on April 26, 2011, at 9:20 a.m., in the hallway, confirmed had not removed gloves and disinfected hands after disinfecting scissors and after placing the dressing on the resident. Resident #2 was admitted to the facility on February 18, 2011, with diagnoses including Intracranial and Intraspinal Abscess, Osteomyletis, and Hypertension. Observation on April 25, 2011, at 5:10 p.m. revealed LPN (Licensed Practical Nurse) #3 washed hands in resident #2's bathroom, came out to the hall to the medication cart, prepared the Humulin R insulin 6 units, applied gloves, entered the resident's room and closed the door, exposed the resident's abdomen and administered the Humulin R insulin without washing the hands after touching the resident's door. Interview on April 27, 2011, at 9:00 a.m., in the conference room, with the Director of Nursing, confirmed the hands were to be washed after touching the door and prior to administering the insulin. Observation during the initial tour on April 25,	F 441	The hand washing audits for medication administration and dressing change will be reviewed by the Director of Nursing and results reported to the Performance Improvement Committee monthly. This committee consists of the Administrator, Consultant Pharmacist, Medical Director, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Housekeeping/Laundry Supervisor, MDS/Care Plan Coordinator, Director of Social Service, Clinical Records Supervisor, Dietary Manager, and Activities Director.	6/1/11

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F 441	Continued From page 16 2011, at 11:20 a.m., in the main hallway revealed on one side of the wall was two water fountains, one for wheelchair access. Continued observation revealed a key with a wooden key ring was laying in the regular water fountain. Interview with the ADON (Assistant Director of Nursing) at the time of observation confirmed the key was not to be in the water fountain.	F 441		